



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

JAMES E. RISCH – Governor  
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0036  
PHONE 208-334-6626  
FAX 208-364-1888

June 19, 2006

Joe F. Rudd, Administrator  
Marquis Care at Shaw Mountain  
909 Reserve Street  
Boise, ID 83712

Provider #: 135090

Dear Mr. Rudd:

On **June 13, 2006**, a Complaint Investigation survey was conducted at Marquis Care at Shaw Mountain by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies, A Form, listing a Medicare/Medicaid deficiency. No Plan of Correction is required for this deficiency; however, the facility is expected to correct the noncompliance.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626.

Sincerely,

  
LORENE KAYSER, L.S.W., Q.M.R.P.  
Supervisor  
Long Term Care

LKK/dmj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

AH  
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # <b>135090</b>	DATE SURVEY COMPLETE: <b>6/13/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARQUIS CARE AT SHAW MT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE ST BOISE, ID</b>	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 285</b>	<p>483.20(m), 483.20(e) PREADMISSION SCREENING</p> <p>A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.</p> <p>A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <p>(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on a complaint from the public, staff interview and record review, it was determined the facility did not ensure a PASARR [preadmission screening for mentally ill individuals and individuals with mental retardation] was completed as required for 1 (#1) resident prior to admission to the facility. Findings include:</p> <p>Resident #1 was admitted to the facility from a local hospital on 4/4/06 with diagnoses including bipolar disorder, congestive heart failure and pulmonary edema.</p> <p>Due to the resident's diagnosis of bipolar disorder, a preadmission screening and resident review was required to be completed by the local state agency prior to the resident's admission to the facility. The state agency completed the PASARR on 4/20/06, sixteen days after the resident was admitted to the facility.</p> <p>An interview was conducted with the DON on 6/13/06 at 12:20 p.m. The DON acknowledged the PASARR had not been completed before resident #1's admission to the facility.</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/14/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/13/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARQUIS CARE AT SHAW MT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 RESERVE ST</b> <b>BOISE, ID 83712</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiency was cited during a complaint investigation at the facility.</p> <p>The surveyors conducting the investigation survey were:</p> <p>Marcia Key, RN Team Coordinator Lisa Kaiser, RN</p> <p>Survey Definitions:</p> <p>MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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HEALTH CARE FINANCING ADMINISTRATION

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